DOCUMENT RESUME

ED 198 468 CG 015 057

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TITLE Paradoxical Prescriptions: A Team Approach to Strategic Family Therapy.
PUB DATE Sep 80
NOTE 25p.: Paper presented at the Annual Convention of the American Psychological Association (88th, Montreal, Quebec, Canada, September 1-5, 1980).

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Behavior Change: *Change Strategies: *Cocounseling: Counseling Effectiveness: *Counseling Techniques: *Family Counseling: Family Problems: Models: Negative Attitudes: *Paradox: Participant Characteristics: *Psychotherapy: Therapeutic Environment

ABSTRACT

This paper describes a strategic, paradoxical therapy approach useful in family therapy. A discussion of the criteria for case selection indicates the ideal profile to be a case which has been treated by several therapists, using various modalities, with virtually no change. Other indications of the need for strategic therapy are discussed, including a high degree of client resistance and a clear, severe, and intolerable symptom. Four major categories of strategic techniques are presented: restraining, positioning, relabelling, and prescribing. Two sample prescriptions, developed by the therapy team and presented to the clients, are described and analyzed to illustrate the incorporation of different strategic techniques. Suggestions for using paradoxical therapy are given with a description of the actual process, i.e., preparing and conducting a session, consulting in the team meeting, and delivering the prescription. The outcomes of the sample cases are discussed and successes and failures of strategic therapy are reviewed. (NRB)

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PARADOXICAL PRESCRIPTIONS

A Team Approach to Strategic Family Therapy

Expanded version of paper
presented at 1980 American
Psychological Association
Meeting in Montreal, Canada

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INTRODUCTION

Historical Background

Credit for initially stimulating my interest in strategic therapy clearly belongs to Jay Haley, first through Strategies of Psychotherapy (Haley, 1963) and later through five years of working together at the Philadelphia Child Guidance Clinic. Cloe Madanes was also an important influence as one of my supervisors at P.C.G.C. (See Mandanes, 1980, for a summary of one of the cases which she supervised.)

The present work stems more directly from the historic conference sponsored in the fall of 1977 by the Ackerman Institute in New York. This was the first opportunity for American mental health professions to be exposed to the strategic family therapy approach developed by the team from Milan, Italy, under the leadership of Mara Selvini Palazzoli. This conference was followed by the publication of Paradox and Counterparadox. (Selvini-Palazzoli et al, 1978)

Immediately following that conference, I began to experiment with the strategic team approach, both at The Family Therapy Unit of the Bristol Hospital, Bristol, Conn. (where I am a family therapy consultant and teacher), and at the Putnam Community Services of the Harlem Valley Psychiatric Center (where I am the clinic director). I later became more aware of other major groups involved in strategic family therapy, particularly the Mental Research Institute in Palo Alto and the team at the Ackerman Institute.

Brief Outline of Our Approach

The work which will be described more fully in later sections is patterned after the work of the Milan group. Sessions are conducted by a team, typically with two therapists in the room and several team members consulting from behind the one-way mirror. The team gives directions to the therapists during the session. At the end of the session, the family is asked to wait while the full team meets and develops a prescription for the family. The family is brought back into the room, at which time the prescription is presented verbally, to be followed up by mailing a written prescription to each family member. Sessions are typically scheduled at 3 or 4 week intervals.

Comparison to Other Strategic Approaches

The present approach has many similarities to other major approaches to strategic family therapy, but also has important differences from each. The following is a brief summary of important similarities and differences as I perceive them. These comparisons should not be viewed overly seriously, especially since the other therapists mentioned might take exception to some of the generalizations.

Like the Milan team, we consistently emphasize analyzing and prescribing the behavior of the whole system, including family members and other professionals. The biggest difference is in therapist behavior during the session. Compared to the Milan group, our therapists intervene more actively and directly and are consistently paradoxical. The Milan team views their role as a neutral, objective process of hypothesis testing. (Selvini - Palazzoli et al,1980)In their recent presentations, there also seems to be a de-emphasis on using paradox.

Compared to the Ackerman strategic teams, it is my impression that we place more emphasis on the use of paradox, while the Ackerman therapists intermix paradox and more straightforward techniques. There also seems to be a major difference in the degree of autonomy of the therapist in the room. At Ackerman, the therapist in the room appears to have a great deal of autonomy, often prescribing the behavior of the team. By contrast, the therapists in the room on our team typically feel like puppets of the team behind the mirror. We emphasize that the therapists in the room should present messages from the team with precision and that they should not begin new interventions or lines of inquiry without coming behind the mirror for consultation.

MRI emphasizes that problems can be maintained at several levels, including the individual, the family, or the larger system including other professionals. (Watzlawick et al,1974) They prefer to work with the smallest unit that is feasible, often working with only one person unless there is clear evidence that this is insufficient. In contrast, we usually work with the whole family and often incorporate other professionals, extended family and even neighbors in our treatment plan. This difference probably arises in part from the kinds of cases we treat. Since most of our cases have intransigent symptoms and a long history of previous treatment, it is usually impossible to ignore the action of other family members or the interventions of other agencies and professionals.

Case Selection

To a large extent, we see the strategic team approach, as we have employed it, as being "defiance-based" rather than "compliance-based" (Rohrbaugh and Tennen et al, 1977). Most of the cases selected for the team to work with have been engaged in "beating the therapist" for years. It has not been unusual to find 10 or 15 years of continuous therapy with many therapists. Probably the clearest indication of the need for strategic therapy is such a history; the ideal profile is a case which has been treated by several competent therapists, using a variety of modalities including family therapy, with virtually no change.

For less "hard-core" cases, the critical question is the degree of resistance, which can be ascertained either from the history of previous treatment or by probing from the team.

It is also ideal to have a clear, severe and "intolerable" presenting problem or symptom. It should seem quite obvious what the problem is and that most people would not choose to live with such a problem. To the extent that either of these conditions are not met, the initial task of the team will be to produce such conditions, by clarifying the presenting problem and by heightening the family's commitment to proving that the problem is intolerable.

It is my impression that most strategic teams, like ours, avoid cases with highly lethal symptoms, such as suicide or family violence. One obvious reason is that major issues of ethics and liability would be raised if a team appeared to be recommending suicidal or violent behavior. It is also more difficult to hold families to an interval of 3 to 4 weeks between sessions if there are threats of violence.

In the present approach, the term "prescription" is used in two different senses. One meaning is to prescribe symptomatic behavior or the behavior of the system. In this respect, prescribing is only one of a variety of strategic techniques. The second meaning is a formal prescription, usually written, which is developed by the team and presented with care. These formal prescriptions, which are the major focus of the present paper, can incorporate prescribing or any of the other strategic techniques.

Categories of Strategic Techniques

A number of recent reviews have attempted to categorize the wide range of possible strategic approaches. The present schema, which is derived from the work of Rohrbaugh and Tennen et al, 1977, Weeks and L'Abate (1979) and Stanton (1980), includes 4 major categories:

(1) restraining, (2) positioning

(3) relabelling, (4) prescribing.

Restraining refers to interventions made by the therapist which appear to advocate that change should not occur, or at least that it should only occur slowly. These techniques can vary from simple "go slow" admonitions from the therapist to more complex interventions advising the patient and family to consider all the possible consequences of change (see Haley, 1976 , pp. 142-150).

Positioning, which is closely related to restraining, refers to the deliberate adoption of an attitude by the therapist which is more negative than that of the patient or family. Examples include seeming more hopeless than a depressed patient or finding more reasons for suspicion than a paranoid.

Relabeling and reframing are probably used by all therapists, but seem to have a special "flavor" when used by strategic therapists. Symptomatic behavior or other "undesirable" behavior is given a new label which attributes positive qualities to the behavior. Stanton (1980) has used the term "positive interpretation" to indicate that this behavior is similar to typical therapist interpretation except that the "underlying" motivation is presented as positive. Because the relabeling appears to be benign, it is much more difficult to resist in the usual ways than a conventional interpretation would be. (See Selvini-Palazzoli et al 1978, pp. 55-66, for an extended discussion of "positive connotation."

Prescribing, when used paradoxically, is usually taken to mean prescribing the symptom. This can include therapist directives to increase the symptomatic behavior or to schedule its occurrence. The Milan group has taken this further by prescribing the behavior of the entire system (not just the symptomatic member.) They also prescribe family rituals which are not paradoxical but which have the effect of removing the participants from a paradoxical bind. (Selvini Palazzoli et al, 1977)

"Prescription" is also used in a second sense, that of a clear directive from the therapist, often in written form. Such written prescriptions are the focus of the remainder of the present paper. As the following section indicates, such written prescriptions may include some or all of the four categories described above.

Sample Prescriptions

In order to illustrate the incorporation of different types of strategic techniques, two sample prescriptions will be presented. The two prescriptions selected are reasonably typical of our work, except perhaps for being milder and less outrageous than many others. The first example incorporates a "ritualized prescription" a la Palazzoli, while the second only comments and prescribes in a very general way,

"Keeping Gina in the Middle" In the first case, the parents, Luigi and Rose, were engaged in a bitter struggle over their only daughter, Gina, aged 20. The family rule was that the three sons belong to mother. Gina was in an unspoken coalition with father, passively resisting Rose's overbearing behavior. Mother would constantly supervise Gina; periodically this would reach a level where Gina would have "psychotic" impulses of harming her mother. Father would then intervene by taking Gina for a ride to cool her off, while mother would go off with Frank, her favorite son who was still living at home.

The first session with the strategic team was held shortly before Christmas, a holiday full of significance for this Italian family. Mother revealed that Frank was planning to announce his engagement. She was highly critical of Luigi, implying (but not stating) that they had little life together. Gina described her parents as "The Odd Couple," seeing them as opposites in every way.

Mother kept bringing the focus back to Gina and to mother's favorite issue, Gina's medications. She insisted on getting an opinion from the team concerning whether it was safe for Gina to have a little to drink at Christmas, since she was on medication. Father thought that Gina should be allowed to drink, just like everyone else, but Mother was skeptical. The one thing the two parents did agree upon was that she should definitely continue on the medication (which the team could not see as doing anything except keeping Gina labelled as a psychiatric patient.)

The following is the prescription given at the end of the first session, including the verbal introduction prior to reading it.

> The team felt that a lot has been going on, and we have a lot to tell you, so we will read your prescription and mail a copy of the prescription to each of you.

THE PRESCRIPTION

As Frank is beginning to form a family of his own, Gina's position in the middle becomes even more important, as was so evident in tonight's session. Gina, your position protects Luigi and Rose from the intensity of their powerful attraction for each other as opposites.

We must agree with the parents that Gina is not ready to reduce medication, but for different reasons. Christmas is clearly a stressful time for the whole family and Gina needs medication right now because of her important role in keeping the whole family balanced. It is important for Gina to stay in the middle and choose in such a way that she sides with both parents at the same time.

Since the drinking question is so important to all of you, we have a very specific recommendation for Christmas Eve. Gina, to side with father, it is o.k. to have a small drink. In order to side with mother, don't drink what father does - drink something mother likes, such as a glass of white wine.

When Gina gets her drink, we want the three of you to look knowingly into each other's eyes and raise your glasses in a silent toast to Gina's becoming a bit more normal.

"The Dangers of Openness." In the second case, George, the husband, was the identified patient. Prior to referral to the strategic team, he had been seen at the same clinic for 1 1/2 years. The presenting problem was his anxiety attacks, which served as justification for his not assuming responsibilities as a husband and father.

There had been several attempts to involve his wife Martha in treatment. The pattern was always the same: George would complain about Martha in his individual sessions, particularly that he wanted her to be more independent and more interesting. When the therapist succeeded in getting Martha to come for couple sessions and began to deal with marital issues, George's symptoms would re-appear and both George and Martha would agree that his problems were more important and that he should be seen alone. The following prescription was the team's response to the same cycle:

The team saw a mixture of good signs and bad signs in today's session.

We saw several things that worried us.

--George seemed very direct in demanding that Martha wake up in the marriage
--Martha seemed too open about her feelings in the session
--Worst of all, both of you seemed very direct toward the team in demanding a clarification of the direction of therapy and asking for more help to change.

We expressed our doubt that it is good for the two of you to have your eyes wide open at the same time. It is even more dangerous that the therapy team will be too direct with you and be too open about what we are doing.

There were some good signs. George showed his willingness to protect Martha by bringing up his symptoms. She can now go back to her comfortable and familiar role of caring for George as if he were her patient. Martha gratefully accepted this generous offer. We are glad to see that George is willing to sacrifice his physical comfort in his daily life for the good of the marriage.

The team agrees to take the conservative course and see George for at least two individual sessions. This will allow George to show his love by accepting the total burden of confusion and anxiety. We will depend on the two of you to decide when it is safe for Martha to come back again.

Analysis of the Sample Prescriptions

Each of the two sample prescriptions incorporates several categories of strategic intervention. As is often the case with paradoxical interventions, it is often necessary to consider the implicit context and what is communicated indirectly, as well as what is stated directly.

Restraining. In the first prescription, Gina's family is told not to stop the medication (with the hope that Gina will resist.) Everyone is further restrained to make only trivial changes, such as taking one drink, rather than more radical changes, and only to become "a bit more normal." The primary hope in these particular "go slow" instructions was to have Gina become impatient and push to be treated more independently.

Positioning. The second prescription contains several examples in which the team's stance was almost a caricature of the couple's feelings. The team was "worried" that George and Martha were being too direct, that there was too much movement, etc. On the other hand, the team acted reassured that the old familiar symptoms were back and that they were returning to their familiar patterns as a couple.

The expectation was that these positions were a radical departure from the positions taken by previous therapists and probably were in marked contrast to what the couple expected from the team. They were probably prepared to resist the usual therapeutic exhortations to be more direct, to face up to the issues between them, not to revert to the previous patient/caretaker relationship, etc. Faced with this new position, the couple had to be the ones arguing in favor of openness and change in the relationship.

Relabeling. Both prescriptions contain examples of relabeling. In the first prescription, the fighting between Luigi and Rose was taken as an indication of their "powerful attraction for each other as opposites," with Gina's position seen as protecting them from this powerful attraction. This redefinition was intended to counter Gina's feeling that she would always be caught in the middle between them because of their hostile, avoidant relationship.

The second prescription utilizes a common reframing in which events usually thought to be positive are labelled as negative and vice versa. George's symptomatic anxiety attacks are also relabelled as a positive sacrifice for the good of the marriage (in contrast to a possible negative interpretation of his attempting to control his wife.)

Her behavior is labelled as a "grateful acceptance of his generous offer" (rather than a victim of this manipulation,or someone who is afraid to assert herself.) To argue against these labels would require the couple to demonstrate that their relationship does not need this symptomatic "sacrifice."

Prescribing. The first prescription contains a carefully developed ritual, embodied in the Christmas toast. The ritual is explicitly designed to allow (and encourage) Gina to remain squarely in the middle between her parents, siding with both of them simultaneously. In addition, the form of the ritual expresses agreement among all three family members on a common goal of Gina's improvement and creates a positive secret rather than the usual negative ones.

The prescription for George and Martha is more general. They are encouraged to continue their familiar pattern of caretaker and patient. Also, rather than fight their resistance to conjoint sessions, George is told to come in alone for at least two sessions and both are instructed not to let Martha come back to therapy until it is safe.

HELPFUL HINTS

General Comments

By now, the reader should be developing an appreciation of the topsy-turvy logic of paradoxical therapy. In this logic, "good" becomes "bad," positive change is labelled as dangerous and the status quo is promoted. It is easy to loose one's bearings once these mental flips are started, and we believe that working with a team is critically important. Without a team, or at least careful supervision, it is almost impossible to remain consistently paradoxical with these difficult cases.

Probably the most important general principle in dealing with highly resistant cases is never to fight with them. Harold Goolishian states this as the cardinal rule that "The customer is always right." We endeavor never to get into any of the expected fights about who should attend sessions, avoiding hospitalization, seeing other therapists or even missing sessions. Instead, all symptomatic behavior, including behavior which undercuts therapy, is prescribed and encouraged, but usually with new labels that make it difficult to continue this behavior. Rather than opposing medication, it is encouraged as a way to maintain the balance. Rather than fighting about individual vs. couple sessions, individual sessions are encouraged as a means of unselfishly accepting the total burden. (In other cases, it would probably be necessary to use other labels to block these types of behavior.)

We reserve the strategic team and the writtten prescriptions only for "hard core," resistant cases. If there seems to be any alternative treatment that might work, try that first, Strategic therapy is extremely difficult and demanding and seems to require considerable precision in execution. I find more straightforward approaches such as the structural approach (Minuchin, 1974) to be much less taxing for me as a therapist, and therefore prefer to try straightforward therapy first. Only after extreme resistance is encountered will I turn to a systematically paradoxical plan.

Preparing for the Session

We generally meet for 15 to 30 minutes prior to a session in order to plan the opening strategy. Failure to do so runs a very high risk of allowing the family to catch the therapists off balance. We review the previous prescription and consider any new information obtained since the last session. We try to consider likely responses from the family and to have a general "game plan" to cover them. Most important, however, is the plan for the beginning of the session. We usually follow the same plan: The therapists should find out in detail the response of the family members to the previous prescription. They are asked to collect this data and not to start any new line of inquiry until one of the therapists consults with the team behind the mirror.

Conducting the Session

As was mentioned in the Introduction, the therapists in the room are generally treated as the "puppets" of the team behind the mirror. While therapists may initially resent the constraints imposed by such a contract, they usually welcome them after they begin to recognize the difficulties involved in conducting strategic therapy.

It is often surprisingly difficult to keep the discussion focussed on one topic and to pursue it systematically. Learning to stick relentlessly to the given topic and avoid being diverted into "significant" areas is one of the early steps in becoming a strategic therapist.

Closely related is the problem of curing therapists of their need to be helpful and "do therapy." Therapists find it hard to remain neutral and noncommital or even act disappointed at signs of change. Most therapists are also concerned that they will have difficulty carrying out the team's suggestions or delivering a prescription with a straight face. The method of delivery is important, but turns out to be less of a problem than anticipated. Family members often react with "you've got to be kidding," but prove to be remarkably easy to convince that you are serious.

Consulting from Behind the Mirror

The one-way mirror has proven to be a crucial ingredient in strategic therapy. It allows a perspective on the family interaction and the therapeutic system that is seldom possible within the room, even with co-therapy. The job of the consultants behind the mirror is to help prevent the therapists in the room from being inducted into the family system and provoked into making the expected "therapeutic" responses.

The consultants should focus on the system composed of the family and the therapists in the room. In particular, they should attend to the responses of the various family members to each therapeutic intervention, to determine what content areas and type of presentation are likely to produce the desired response. It is also very important to be alert to signs that the therapists in the room are becoming immobilized or are getting into hot water by attempting to respond to loaded questions from the family or other kinds of "bait." When this happens, one of the therapists must be summoned behind the mirror.

Suggestions to the therapists must be as explicit as possible. One should never underestimate the power of the family to divert the therapist or get the therapist to soften the intervention. Interventions should be confined to a single theme. The exact language should be rehearsed, with suggestions of how to follow up after the initial intervention is made.

The consultants should also be specific about the extent to which the intervention is to be attributed to the team behind the mirror and what relationship between the therapists and the consultants behind the mirror will be portrayed to the family. Often it is extremely useful to pretend that there is a disagreement between the therapists, who are sympathetic and optimistic toward the family, and the consultants behind the mirror, who are skeptical and pessimistic. (See Papp, 1980, for ideas for using this "Greek Chorus.")

The consultants will also be gathering data and ideas for the final intervention. Some of these ideas can be tentatively explored during the session. Often, however, it is necessary for the consultants to restrain the therapists from making major interventions during the session, admonishing them to"save the best for later."

The Team Meeting

After the family has been sent to the waiting room and the team has assembled, there is usually a good deal of ventilation. Typically the whole team, particularly the therapists in the room, feel that they have been restraining themselves (often from laughter) with a great deal of effort. It is important for this ventilation to occur. The therapists also need to hear that they have done a good job, since they have worked hard to avoid "doing therapy."

The Milan team advocates moving next to an "orgy of linear hypotheses." Our experience is similar to theirs - that it is extremely difficult to jump directly to a circular, systemic view of the situation. This is the area in which the team is invaluable. If one team member argues that Mother is the villain and offers a punctuation that suggests that she starts the interactional sequence, it is usually possible to find another team member who can offer an argument which begins with Father, or one of the children.

The whole team usually experiences an "Aha" reaction when a truly systemic view has been achieved, accompanied by a marked reduction in tension within the team. On a content level, a successful systemic hypothesis should include all of the linear hypotheses which have been previously offered. In an important sense, it is true that every team member is right (somewhat akin to the seven blind men describing the elephant.) The only danger in the process is that one or more team members will be allowed to over-ride others, by virtue of greater status or persuasiveness. If the team operates with the assumption that everyone is correct, a circular hypothesis will eventually emerge.

Another major temptation is to jump directly to suggestions about possible interventions to be made. If this is done prior to achieving a systemic viewpoint, it can easily become an escalating contest to see who can devise the most clever or most complicated intervention. Often it is helpful to go back to the question of goals - what the long-range goals are and what is this particular intervention intended to accomplish.

The Prescription

The elements of the prescription have already been discussed, but there are several useful guidelines for incorporating them into a written prescription.

It is critical (and extremely difficult) to keep the prescription simple. Prescriptions that are too long and complex will exhaust and confuse the team, resulting in a considerable drop in the precision with which the prescription is written. Such prescriptions also have much less impact on the family members.

The impact of the prescription seems to be greatly enhanced by incorporating the languages of the family. This includes specific words or phrases, favorite metaphors, and their general frame of reference.

A useful goal is to incorporate or comment upon the major events and trends of the session. This includes the actions and responses of the therapists, as well as the team behind the mirror. Again, it is helpful to adopt the stance that everything that happens is "correct." On occasion, this has included such diverse examples of behavior as therapists being too helpful, splits and arguments between team members, therapists falling asleep, and team members forgetting sessions. Everything becomes "grist for the mill" and can usually be used to advantage.

It is particularly important to consider the tone and style of presentation, in order to enhance the effect of the prescription and achieve the desired effect. At times it may be useful to be crisp and authoritarian, or deliberately metaphorical or vague, or to adopt a puzzled and "one-down" attitude. These attitudes can be attributed to the whole team, or differences within the team can be enhanced or manufactured.

Delivering the Prescription

The delivery of the prescription is often the most crucial part of the session. Having the intervention completely written out has proven to be the only way to insure that the therapists can do a satisfactory job of delivery. We allow only the most experienced strategic therapists to "wing it," and only with cases that are clearly going well.

After reassembling the family, the treating therapists always begin by stating that the team has developed a written prescription which will be read to them and then sent in the mail. (This proves to be crucial in helping the therapists to make a graceful exit after delivering the prescription.)

The prescription is then read slowly and carefully, with the appropriate tone. This task is usually divided between the two therapists, with consideration given as to which therapist should read which parts.

Interruptions and questions are not allowed during the delivery of the prescription. They are usually dealt with by ignoring or simply saying "Let me finish reading this before you say anything." Comments and nonverbal gestures during the prescription are very common, and it is the job of the team behind the mirror to pay particular attention to these reactions.

Once the prescription has been delivered, it is critically important that the therapists make a quick exit. Otherwise, the effect of the intervention is diluted, usually by having the therapists letting themselves be trapped into answering questions or elaborating further. The best dodge has proven to be a re-statement of the fact that the family will get the prescription in the mail and that it will probably become clearer then.

THE QUESTION OF EFFECTIVENESS

Does It Work?

It should be acknowledged from the outset that we do not have a large number of completed strategic cases to offer as evidence of effectiveness. The evidence is compelling to the extent that one is willing to compare the outcome of a given case to the previous treatment history of that case. Almost all of our cases have a lengthy course of previous treatment, often with several therapists and a variety of treatment modalities with little or no improvement. Measured against such evidence of resistance to change, major changes on any of these cases become more impressive.

In the case of Gina and her family, there was a history of over 15 years of struggle with the mental health profession, beginning when she was a toddler. Treatment had included parent counselling, special schooling, psychiatric hospitalization, individual and family therapy. At the time of referral, she was on a major tranquilizer, was reported to be hallucinating and was seen as potentially violent and dangerous toward her mother.

After 10 sessions over a period of eight months, the situation had changed radically. During a two-year follow-up period, she has continued to improve (and her parents have continued to tolerate the changes.) These changes occurred in virtually every sphere of Gina's life: She completed high school and was considering college. Her violent impulses and hallucinations "disappeared." She took herself off of medication with no ill effects. She made female friends and began to date. She also developed hobbies and other social outlets. The only danger signal came when Gina called (herself) for an appointment. It turned out that she was worried about how her mother would react to the impending marriage of Gina's brother, Frank. All that was needed to consolidate Gina's gains was our continued skepticism about her improvement and the suggestion that she help her mother by developing some of her old problems.

George (and occasionally Martha) was seen for 12 sessions over approximately one year. Previous therapy efforts over 1 1/2 years with two therapists had produced only modest symptomatic improvement. He still appeared to be holding onto his patient status and anxiety attacks, which usually resulted in trips to the emergency room. His wife seemed only too happy to comply. She put no demands on him as a father or husband and tolerated an open affair.

At the end of treatment and a two year follow-up, George had exceeded every therapeutic goal. His anxiety attacks were gone and he felt positive and self-assured. He broke off with his lover, made a commitment to work on his marriage and decided to have another child.

Not only had he become more of a father, he even decided to be present while his wife went through natural childbirth (despite a blue collar background, which offered little support for this.) He was a success at work and was voted "Volunteer Fireman of the Year," out of several hundred candidates. Of course he did not thank the team for any of these changes.(See below.)

Does It Fail?

Unfortunately, or perhaps fortunately for our credibility, we must admit that we have also failed at times. Of course we tend to attribute these failures to our mistakes in carrying out the approach, rather than the approach itself.

The most common form of failure seems to be one of a variety of types of non-engagement, the most difficult manifestation of this is a family which is too passive. Some families have shown a remarkable ability to withstand being provoked into fighting, despite some rather extreme efforts. Such extreme passivity may be one of the best indicators that a strategic approach is contraindicated (although any other approach will probably be even more frustrating.)

Similar problems are encountered with extremely chaotic, crisis-oriented families. In some of these families, it seems impossible to channel the fight into a few areas. It is almost as if the family hardly notices the most dramatic efforts of the therapeutic team. The situation is further complicated by the frequent crises, which often seem difficult to ignore, particularly when they involve numerous outside agencies.

Even in less chaotic cases, those cases which involve potentially dangerous crises of acting-out may be difficult to treat with the strategic team approach. Because of the nature of these crises, control of the case is often lost when other professicnals hospitalize, prescribe medication, or schedule emergency sessions. Such possibilities can only be countered by having the team anticipate them and take control by prescribing and relabelling their occurrence.

Earlier it was mentioned that we avoid engaging in power struggles over missing members at the sessions. Nevertheless, it is important to recognize that the absence of crucial members seems to diminish the possibility of success. We typically send prescriptions to missing members and use a variety of ploys to get them in, but often they seem immune to strategic provocation and work on other family members to resist the crazy efforts of the team.

The final form of non-engagement seems largely preventable. Often we have been seduced by apparently friendly referral sources and have been overly eager to accept cases they refer. Often the referral source does not wish to relinquish the case and has decidedly mixed feelings about having the team succeed where he or she has failed.

We have learned through bitter experience to keep our enthusiasm in check, accepting the case only when it becomes clear that the referral source has tried everything and has given up completely.

Occasionally it has happened that the strategic approach has not succeeded even after the family has been "hooked" in strategic treatment. These cases usually are not clear failures; instead it seems that treatment has bogged down.

Often the problem seems to be one of the therapeutic contract. The initial contract is frequently too vague, so that it is impossible to tell whether therapy is succeeding or not. At times, the initial contract may have been satisfactory, but careful analysis reveals that the contract has undergone subtle changes. Gradually, the team has begun to wish to accomplish too much, or may have shifted to problems such as marital issues without tying them to the presenting problem. All of these difficulties can generally be handled by returning to the initial contract and recontracting.

The other typical source of difficulty is that the team has "chickened out." This may take a variety of forms: The team may become too excited and react too positively to initial signs of improvement, rather than remaining neutral or somewhat skeptical. Or the team may get scared and be unwilling to push things far enough. (This is particularly easy to do if one is working alone or is new to the strategic approach.) A more subtle variation of this is a gradual shift to a more straightforward approach, or a sudden conviction that some other approach should have been tried first.

While on the topic of failure, it is important to underscore that this approach does not fail in the ways that many people seem to expect. We have had no spectacular lawsuits or angry clients complaining to the authorities. None of our prescriptions have backfired. (But everyone seems to have heard their own horror stories, which usually involve non-paradoxical suggestions that a patient should hurt or kill himself.) The chief problem seems to be hostility from other professionals, not from the clients themselves.

Even If It Works, Is It Worth It?

Even if one accepts the conclusion that strategic therapy may be quite effective, it is still possible to question whether the approach is worthwhile. The answer is dependent upon to whom the question is addressed.

From the standpoint of the patient and the family, the answer is "yes," if judged by results. It has often been possible to free patients from chronic, severely debilitating symptoms. Perhaps equally important, families are also freed from a lifelong involvement with therapy and the mental health system. Of course even though the results may be spectacular, this does not mean that the family will be grateful to the therapist (which would be a dangerous sign with this approach.)

From an administrative point of view, at least my own, the answer is also "yes." This approach is very promising in putting an end to chronic weekly therapy sessions. Instead of weekly individual sessions, a team session is held every 3 or 4 weeks. This still involves more man-hours than the traditional approach, so that it is cost-effective only because it works and makes it possible to terminate the interminable. The strategic approach also has the unexpected benefit of making the most horrendous and intractable cases suddenly become attractive.

There are administrative problems, particularly from a billing standpoint. Most billing mechanisms, whether public or private, charge by the session rather than the man-hours involved. It is unlikely that anyone would pay the true costs of strategic team treatment. A full team approach is rarely used in private practice and is often justified at least partially as training. The only solution to this dilemma would be to have payment linked to results.

The answers given by therapists vary widely. It has not been unusual in my experience to have therapists work closely with a team, experience the power of this approach, and yet decide against using strategic therapy themselves. Many of these therapists find that they simply cannot think this way, or have personal objections to doing it themselves. At least equally important, they find that strategic therapy is not gratifying in the same way that orthodox therapy often is. There are no grateful clients. They range from being puzzled and neutral about therapy, feeling that change had little to do with therapy, to open hostility. A case in point is George, who made a special appointment to come in and prove to the team that he had made all of these changes in spite of the team.

Obtaining gratification from such a case depends on being able to focus on results and believe that the treatment was responsible, no matter what the patient says. Of course, it is invaluable to have other team members with whom to talk about the results, since little direct gratification comes from the patient.

The reader will have to find his or her own answer. If you are tempted to try it yourself, go into strategic therapy with the full recognition that it is hard work and that it is important to stick with it. Don't do it alone, and ideally find someone who knows how to do it. Finally, proceed with care, and only when all else has failed.

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